STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G104	A. BUILDING _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENVILLE LOOP GROUP HOME	6100 GREENVILLE LOOP ROAD WILMINGTON, NC 28409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint investigation for intakes NC00171492 and NC00171845 was conducted during the recertification survey. There were no deficiencies cited as a result of the complaint investigation.	W 000		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure client #5 had the right to access his personal grooming supplies. This affected 1 of 3 audit clients. The finding is: During morning observations in the home on 1/26/21 at 9:03am, client #5's mouthwash, toothbrush and toothpaste were locked in an office in the home. Interview on 1/26/21 with Staff A revealed client #5's grooming items were kept there because he will eat his toothpaste and drink his mouthwash. The staff stated, "He'll eat the whole tube" of toothpaste. Review on 1/26/21 of client #5's record did not indicate his right to access his mouthwash or toothpaste should be restricted. Interview on 1/26/21 with the Qualified Intellectual	W 137		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 137	Continued From page 1 Disabilities Professional (QIDP) confirmed client #5 should have free access to his mouthwash and toothpaste.	W 137		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all staff were sufficiently trained to implement the facility's current COVID-19 visitation protocols. The finding is: Upon arrival to the day program and group home during the survey on 1/25 - 1/26/21, the surveyor was not screened for COVID-19. Interview on 1/26/21 with Staff A revealed they do not screen visitors since no visitors are currently allowed in the home due to COVID-19. Review on 1/26/21 of the facility's Non-Health Care Employee Symptom Screening Checklist revealed questions regarding close contact within the last 14 days with someone diagnosed with COVID-19 and the presence of COVID-19 symptoms (i.e. Fever, shortness of breath or difficulty breathing, new cough, new loss of taste or smell). Interview on 1/26/21 with the Social Worker indicated visitors should be screened for	W 189		

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W 189	Continued From page 2 COVID-19 by asking these questions upon arrival to the facility.	W 189		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure techniques to manage client #5's inappropriate behaviors were included in a formal active treatment plan. This affected 1 of 3 audit clients. The findings are: During observations in the home throughout the survey on 1/25 - 1/26/21 a string of large bells were hanging from the door knob of client #5's bedroom door. As the client entered or exited his bedroom, the bells would make a sound. During additional morning observations in the home on 1/26/21 at 9:03am, client #5's mouthwash, toothbrush and toothpaste were locked in an office in the home. Interview on 1/26/21 with Staff A revealed client #5's grooming items were kept there because he will eat his toothpaste and drink his mouthwash. The staff stated, "He'll eat the whole tube" of toothpaste. Interviews on 1/26/21 with Staff A, C and D revealed the bells on client #5's door knob were	W 288		

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W 288	Continued From page 3 in place to "alert" them of his movements because "he sneaks" around the home and this allows them to hear him. The staff indicated this was a way to "monitor" him. Review on 1/26/21 of client #5's Behavior Intervention Plan (BIP) dated 6/20/20 revealed objectives to physical aggression, self-injury, elopement (actual or attempted), stealing, and regurgitation. Additional review of the plan's restrictive programmatic procedures indicated exclusionary time out, personal restraint, blocking/redirection fail, and outside door alarms were in place. Additional review of the BIP also noted the client's toothbrush should be kept locked in the office and the reinforcer and snack supply closet should also be kept locked to address his inappropriate behaviors. Further review of the BIP did not reveal a technique of locking away client #5's grooming items (i.e. mouthwash and toothpaste) or the use of bells on his bedroom door to address his inappropriate behaviors. Interview on 1/26/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5's mouthwash and toothpaste should not be kept locked and staff should not be utilizing bells to monitor the client's movements in/out of his bedroom. The QIDP acknowledged these techniques were not included in client #5's BIP.	W 288		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368		

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W 368	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #1's medication was administered in accordance with physician's orders. This affected 1 of 4 clients observed receiving medications. The finding is: During evening observations of medication administration in the home on 1/25/21 at 5:25pm, client #1 ingested Flomax .4mg. The client did not consume food prior to receiving his medication. Review on 1/26/21 of client #1's physician's orders dated 1/1/21 - 3/1/21 revealed an order for Flomax .4mg, take 1 capsule by mouth every day at 6 pm, "Give 30 minutes after a meal." Interview on 1/26/21 with the facility's nurse confirmed client #1's Flomax should be administered as indicated on his physician's orders.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #5's medication was administered without error. This affected 1 of 4 clients observed receiving medications. The finding is:	W 369		

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W 369	Continued From page 5 During morning observations of medication administration in the home on 1/26/21 at 7:40am, client #5 ingested 17 grams of Miralax powder along with three other medications. Immediate interview with the medication technician confirmed client #5 consumed a "capful" of Miralax which equals "17 grams". Review on 1/26/21 of client #5's physician's orders dated 1/1/21 - 3/1/21 revealed an order for Miralax powder, "mix 1/2 capful (8.5 grams)" with 8 oz of water and take by mouth every day at 8:00am. Interview on 1/26/21 with the facility's nurse confirmed client #5 should have received a 1/2 capful of Miralax as indicated on his current physician's orders.	W 369		